



**NYU Langone Medical Center
Electronic Health Information System**

I have received the NYU Langone Medical Center Electronic Health Information System Fact Sheet. It describes (1) the purpose of the NYU Langone Medical Center Electronic Health Information System; (2) how it works; and (3) how the providers participating in the NYU Langone Medical Center Electronic Health Information System will record and access my health information.

I understand that by signing this form, NYULMC providers directly involved in my care may access my health information, including my electronic prescription records, and that it will be available to my other health care providers in the system, as described in the Fact Sheet.

I acknowledge receipt of the Electronic Health Information System Fact Sheet and consent for all of my providers who participate in the NYU Langone Medical Center Electronic Health Information System to create and/or access and use my electronic health record (EHR) in order to provide my medical care. I understand that this consent will remain in effect unless revoked in writing.

Signature of patient or representative authorized by law

Date

If not the patient, name (print) of person signing this form:	Authority to sign this form on behalf of the patient (example: parent, legal guardian or health care proxy):
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10/08/2009